

Indiana State Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 010235 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 07/30/2015 |
| NAME OF PROVIDER OR SUPPLIER HARBOUR ASSISTED LIVING OF FORT WAYNE | | STREET ADDRESS, CITY, STATE, ZIP CODE 3110 E COLISEUM BLVD FORT WAYNE, IN 46805 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| R 000 | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00178957.</p> <p>Complaint IN00178957 - Unsubstantiated, due to lack of evidence.</p> <p>Survey Dates: July 30, 2015</p> <p>Facility number: 010235 Provider number: N/A AIM number: N/A</p> <p>Census bed type: Residential: 62 Total: 62</p> <p>Census payor type: Other: 62 Total: 62</p> <p>Sample: N/A</p> <p>Harbour Assisted Living of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00178957.</p> | R 000 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE